

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3742AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/17/2009
NAME OF PROVIDER OR SUPPLIER HORIZON HILLS RES GRP CARE 3		STREET ADDRESS, CITY, STATE, ZIP CODE 8055 MOHAWK LANE RENO, NV 89506		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	<p>Initial Comments</p> <p>Surveyor: 28725</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.</p> <p>This Statement of Deficiencies was generated as a result of an annual State Licensure survey conducted in your facility on 12/17/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division.</p> <p>The facility is licensed for five Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was three. Three resident files were reviewed and two employee files were reviewed. One discharged resident file was reviewed.</p> <p>The facility received a grade of A.</p>	Y 000		
Y 883 SS=A	<p>449.2742(7) Medication / Resident Refusal</p> <p>NAC 449.2742 7. If a resident refuses, or otherwise misses, and administration of medication, a physician must be notified within 12 hours after the dose is refused or missed.</p> <p>This Regulation is not met as evidenced by: Surveyor: 28725</p>	Y 883		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVN3742AGC	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/17/2009
NAME OF PROVIDER OR SUPPLIER HORIZON HILLS RES GRP CARE 3			STREET ADDRESS, CITY, STATE, ZIP CODE 8055 MOHAWK LANE RENO, NV 89506		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 883	Continued From page 1 Based on interview and record review on 12/17/09, the facility failed to notify a physician when 1 of 3 residents refused to use his prescribed medicated shampoo (Resident #1). Severity 1 Scope 1	Y 883			
Y 936 SS=F	449.2749(1)(e) Resident file-NRS 441A Tuberculosis NAC 449.2749 1. A separate file must be maintained for each resident of a residential facility and retained for at least 5 years after he permanently leaves the facility. The file must be kept locked in a place that is resistant to fire and is protected against unauthorized use. The file must contain all records, letters, assessments, medical information and any other information related to the resident, including without limitation: (e) Evidence of compliance with the provisions of chapter 441A of NRS and the regulations adopted pursuant thereto. This Regulation is not met as evidenced by: Surveyor: 28725 Based on record review on 12/17/09, the facility failed to ensure 1 of 3 residents complied with NAC 441A.380 regarding tuberculosis testing (Resident #1 - missing a positive tuberculosis skin test or evidence of a two-step tuberculosis skin test). Severity: 2 Scope: 3	Y 936			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.